Bucks County Gastroenterology Associates, P.C.

New Patient Medical History Intake Form

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This consent authorizes Bucks County Gastroenterology Associates, P.C. to use and disclose health information about you, for treatment and health care operations.

EXPLANATION OF RIGHTS – READ THIS BEFORE SIGNING THE CONSENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

Bucks County Gastroenterology Associates has a Notice of Privacy Practices that describes how we use and disclose protected health information about you and how you can access your protected health information. You may review our current notice prior to signing this consent.

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain. You may obtain a revised notice by submitting a written request to our Privacy Officer.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree to any requested restrictions. However, if we agree to a requested restriction, we are bound by the restriction.

You have the right to revoke this consent, except to the extent that we have taken action in reliance on the consent. To revoke this consent, you must submit a written revocation to our Privacy Officer.

Practice Name: Bucks County Gastroenterology
Address: 301 Oxford Valley Road, Suite 701, Yardley PA 19067
Telephone #: 215-321-7221
Facsimile #: 215-321-9109

CONSENT

I have read and understand the above Explanation of Rights and have been provided the opportunity to review the Notice of Privacy Practice for Bucks County Gastroenterology prior to signing this consent. I authorize Bucks County Gastroenterology to use and disclose health information to the parties I provided for treatment, payment and health care operations in accordance with its Notice of Privacy Practices.

I acknowledge that the information and contacts I provided today is accurate.

I hereby authorize Bucks County Gastroenterology to release any information acquired in the course of my examination or treatment for insurance claims, and authorize payment directly Bucks County Gastroenterology of the surgical and/or medical benefits, if any, otherwise payable to me for their services. I understand I am financially responsible of all charges not covered by this authorization and guarantee payment of this account.

_____ _____

Signature of Patient/Guardian Date

Patient Name: _____ Date of Birth: _____